EXHIBIT 6

NYC DOC VISITOR SEARCH CLAIM FORM

You must, Sign, & Mail This Claim Form by ______, 2019 to receive payment.

THE ENVELOPE MUST BI AND MUST BE MAILED IN THE ENCL								
NYC DOC Visit P.O. I		tlement, c/o County, State, z	Zip					
Please read the enclo	osed notice b	efore completi	ng this claim for	rm.				
CLASS MEMBER INFORMATION								
The information given here is private, and will be used only for purposes of processing your claim.								
[NAME AND ADDRESS OF CLASS MEMBER TO BE PRE-POPULATED BY ADMINISTRATOR]								
Update Contact Information (if different	than above):							
Last Name of Class Member: First Name: Middle Initial (if an								
Mailing Address of Class Member:								
City:			State:	Zip Code:				
Social Security Number or I-TIN (if any): -		_	(Month, Day, Year					
authorities. You can ask for a refund when you file yo	our tax return.							
Phone of Class Member (optional):	٦							
	_							

Verification & Release:

•	I visited (or attempted to visit) an inmate who was housed at a New York City Department of Correction ("DOC") facility between November 23, 2012 and, and was subject to an invasive search by a DOC employee (or at the direction of a DOC employee), which included, but was not limited to: more than accidental or incidental exposure of, or contact with, my breasts, genitals, or buttocks as part of the search process.
•	Additional information, if known, to assist in the processing of your claim:
	nly answer these questions if during the class period you were ever denied a visit or had your visit stricted due to contraband:
	1. Did you visit more than one time?
	Yes; or
	No.
	2. Were you invasively searched on a visit where you were <u>not</u> found with contraband?
	Yes; or
	No.
•	In consideration for the payment of this sum, I release and discharge the Defendants, and all of their respective affiliates, subsidiaries, parents, successors and predecessors, officers, directors, agents, employees, attorneys, advisors and insurers from any and all claims that arise out of me being invasively searched by a DOC employee as a visitor to a DOC facility between November 23, 2012 and [date of preliminary approval].
•	I agree that the U.S. District Court for the Southern District of New York Court has the authority to rule on my claim for payment as part of the Settlement Class, and that the Court shall maintain jurisdiction on this matter for the purposes of enforcing the settlement and Release as power to rule on my claim as a Settlement Class Member, and that the Court has the power to enforce the Release described below.
•	By signing this form, I declare under penalty of perjury under the laws of the United States that the information provided on this form is true and correct to the best of my knowledge, belief and recollection.
Da	nte:
	(Sign your name here)
	(Print your name here)

NYC DOC VISITOR SEARCH CLAIM FORM

You must, Sign, & Mail This Claim Form by _____, 2019 to receive payment.

THE ENVELOPE MUST BE <i>POSTMARKED NO LATER THAN, 2019</i> , AND MUST BE MAILED IN THE ENCLOSED RETURN ENVELOPE (OR ANY OTHER ENVELOPE) TO:																										
NYC DOC Visitor Search Settlement, c/o P.O. Box, County, State, Zip																										
Please read the enclosed notice before completing this claim form.																										
CLASS MEMBER INFORMATION																										
The information given here is private, and will be used only for purposes of processing your claim.																										
Last N	Name of	· Cla	ss M	emb	er:]	Firs	t Na	me:		Ι								M	ſiddl	e Ini	tial (if an
City:	•																	Stat	e:			Zip	Cod	le:		
Social	Social Security Number or I-TIN (if any): Date of Birth (Month, Day, Year):																									
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author	If you drities. Yo	ou ca	n ask	for	a refu	ınd v						% of	your	pay	ment	will	be w	ithh	eld ar	ıd pai	id to	the f	eder	al tax	ing	
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Verification & Release:

Correction ("DOC") facility between Nov invasive search by a DOC employee (or at	te who was housed at a New York City Department of vember 23, 2012 and, and was subject to an the direction of a DOC employee), which included, but was dental exposure of, or contact with, my breasts, genitals, or
Additional information, if known, to assist	in the processing of your claim:
Only answer these questions if during the crestricted due to contraband:	lass period you were ever denied a visit or had your visit
1. Did you visit more than one time?	
Yes; or No.	
	1
2. Were you invasively searched on a visit v	vnere you were <u>not</u> found with contraband?
Yes; or No.	
their respective affiliates, subsidiaries, pare employees, attorneys, advisors and insure	am, I release and discharge the Defendants, and all of ents, successors and predecessors, officers, directors, agents, ers from any and all claims that arise out of me being e as a visitor to a DOC facility between November 23,
rule on my claim for payment as part of jurisdiction on this matter for the p	e Southern District of New York Court has the authority to f the Settlement Class, and that the Court shall maintain urposes of enforcing the settlement and Release as Class Member, and that the Court has the power to enforce
, , ,	alty of perjury under the laws of the United States that the ne and correct to the best of my knowledge, belief and
Date:	
	(Sign your name here)
	(Print your name here)